DECLARATION AND REQUEST FOR REPLACEMENT LICENSE

Return this completed form and the old license (if you still have it), with a check or Money Order for the application fee of $25 for each license requested, (payable to NHAP) to the following address:

Nursing Home Administrator Program
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416

PRINT OR TYPE

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER *

MAILING ADDRESS *(Number)*	*(Street)*	WORK TELEPHONE NUMBER ( )

ADDRESS FOR PUBLIC RECORD (Number)	(Street)	(City)	(State)	(Country)	(Zip Code)

(City)	*(County)*	*(State)*	*(Zip Code)*	HOME TELEPHONE NUMBER ( )

E-MAIL ADDRESS	LICENSE NUMBER	DATE OF BIRTH

* Disclosure of your social security number (SSN) is mandatory. The Health and Safety Code and Public Law 94-455 (42 USCA©(2)©) and Section 11350.6 of the Welfare and Institutions Code authorize collection of your SSN. If you fail to disclose your SSN, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

REQUEST IS MADE FOR:

- ☐ Replacement NHA Wall Certificate
- ☐ Replacement Preceptor Wall Certificate
- ☐ Replacement C.E. Provider Wall Certificate
- ☐ Replacement C.E. Provider Certificate

REASON FOR REQUEST:

- ☐ Lost
- ☐ Name Change **(Affidavit Needed)**
- ☐ Original License or Certificate Not Received (No Fee If Within 2 Months)
- ☐ Original License or Certificate Not Printed Correctly (No Fee Required)
- ☐ Address Change
- ☐ Stolen
- ☐ Mutilated
- ☐ Destroyed
- ☐ Status Change
- ☐ Active
- ☐ Inactive

**** CERTIFICATION—IMPORTANT—PLEASE READ BEFORE SIGNING—If not signed, this application may be rejected. ****

I certify under penalty of the perjury laws of the State of California that the information I have entered on this application is true and correct to the best of my knowledge. I further understand that any false, incomplete, or incorrect statements may result in denial of this replacement license application by the Nursing Home Administrator Program(NHAP). I fully understand that NHAP may require additional documentation prior to approving and issuing a duplicate license.

APPLICANT'S SIGNATURE **	DATE SIGNED **

APPLICANTS—DO NOT USE THE SPACE BELOW—FOR NHAP USE ONLY

CASH. # _____	STATUS ☐ Approved ☐ Rejected ☐ Denied	
NHAP INITIALS _____	☐ Missing Information	☐ Fee
AMOUNT _____	☐ Name Change Affidavit	
	STAFF	DATE PROCESSED